Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: W.T. Anesthesia P.O. Box 4157 Midland, Tx 79704	MFDR Tracking #: M4-07-7358-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: New Hampshire Insurance Co. Rep Box: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary; taken from the Table of Disputed services: "AIG says a CRNA is not payable for this procedure in a Non – teaching capacity! What - - CRNA's are payable for anesthesia services @ $47.37 per unit of service do not have to be in teaching!! ASA code = 01830 Time = 115 minutes See attached claim & anes records."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $506.86
3. CMS 1500(s)
4. EOB's
5. Anesthesia Medical Record

Sent
JAN 15 2008
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS'
COMPENSATION

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "This is a fee dispute. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. Labor code Section 413.011(d). The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines and whether the documentation provided supports the level of services. All reductions of the disputed charges were made appropriately."

Principle Documentation:

1. Response to DWC 60
2. Position Statement

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
01/24/07	150 /150	01830-QZ	1 - 5	$215.07
Total Due:				$215.07

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. This dispute relates to procedures/services that were billed under procedure code 01830-QZ for DOS 01/24/07.

2. This service was initially denied by the Respondent with denial reason:

- 150– "Payment adjusted because the payer deems the information submitted does not support this level of service. The Division clarifies reason code 150 code shall be used for medical necessity or fee denials. "

3. This service was denied after reconsideration by the Respondent with denial reason:

- 150– "Payment adjusted because the payer deems the information submitted does not support this level of service. The Division clarifies reason code 150 code shall be used for medical necessity or fee denials."

4. In this case the Requestor submitted relevant documentation to substantiate the level of service billed. Reimbursement for procedure code 01830-QZ is as follows:

   115 minutes ÷ 15 = 7.67units =7.7units
   CPT code 01830 =3.00 units ÷ 7.7 units = 10.7 units
   $16.08(2007conversion factor) x 125%= $20.10
   $20.10 x 10.7 units =$215.07 (MAR)

5. Therefore, according to rule 134.202(c) (1) reimbursement of $215.07 is recommended

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $215.07 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER :

Authorized Signature	Medical Fee Dispute Resolution Officer	01/11/08 Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.